trip might involve the business traveler who arrives in a city by plane, transfers to a light rail system that deposits her in the urban center where she checks-out an electric ''station car'' to travel to meetings in three different locations. Upon concluding business, she returns to the light-rail station, plugs in the rented station car for the next driver, hops on the light rail and returns to the airport. This business traveler has left no environmental footprint during her visit to your community.

Enhance the environment—relieve traffic congestion—increase alternative fuel use—effectively demonstrate viable and sustainable alternative fuel vehicles and their interconnected use in transportation networks—bring together all levels of government and industry as partners in this effort—and educate the public that alternative fuel technologies work . . . these are the goals of the Alternative Fuel Vehicles Intermodal Transportation Act. The price tag for reaching these goals is relatively modest; the price for not supporting this type of paradigm shift in the way we move people and goods is incalculable. And it is a price that will be paid not just with dollars, but with our natural resources, our air, and the quality of life for generations to come. I hope many of my colleagues will recognize the value and importance of this innovative program and will support this important legislation.

PRESCRIPTION DRUGS

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 4, 2000

Mr. CRANE. Mr. Speaker, as the Congress continues to debate the question on how to provide seniors with affordable prescription drugs, I wanted to bring to my colleagues attention the article ''Prescription Drug Costs: Has Canada Found the Answer?'' by William McArthur, M.D. Dr. McArthur is a palliative care physician, writer and health policy analyst in Vancouver B.C. Some of our colleagues have been touting the affordability of prescription drugs in Canada and in some cases sponsoring bus trips for seniors across the border to obtain these drugs. We should be skeptical of this approach because, in reality, the Canadian government drug mandates harm patients and increase the costs in other sectors of the health care system.

The Canadian bureaucracies cause significant delays in access to new and innovative drugs. First, at the federal level, Canadians wait up to a year longer than Americans do for approval of new drugs. Then the delays continue at the provincial level where various government ''gatekeepers'' review the ''therapeutic value'' of prescription drugs before they are included in the formulary. The length of the delays varies widely. The government officials in Nova Scotia approve drugs for its formulary in 250 days, while the wait in Ontario is nearly 500 days.

Canadian patients are often forced to use the medicines selected by the government solely for cost reasons. Patients who would respond better to the second, third, or fourth drug developed for a specific condition are often denied the preferred drug, and are stuck with the government-approved ''one size fits all'' drug.

I urge my Colleagues to read this article and keep in mind that while prescription drugs appear to cost less in Canada than in the United States, there is a costly price associated with the Canadian system that ultimately translates into a lack of quality care for patients.

[From the National Journal's Congress Daily, Oct. 2, 2000]

PRESCRIPTION DRUG COSTS: HAS CANADA FOUND THE ANSWER?

(By William McArthur, M.D.)

Some Americans faced with the rising costs of prescription drugs look longingly at Canada, where prescription drugs appear to cost less than in the United States. The fact is that, while some drugs do cost less in Canada, others don't. Furthermore, many drugs are not available at any cost in Canada. The effect of Canadian policies is to restrict the overall availability of prescription drugs through a combination of a lengthy drug approval process and oppressive price controls.

First of all, Canada's federal drug approval process takes much longer than that of the U.S., resulting in delayed access for Canadians to new drugs. For example, Canadian acceptance of the drug Viagra came a whole year after it had been available in the U.S. For 12 months Canadians who needed Viagra, or another of the many drugs delayed or denied approval, had to go to the U.S. to get their medication.

Even if a drug wins federal approval, it faces 10 more hurdles to become widely accessible—the 10 provinces. Each province has a review committee that must approve the drug for reimbursement under the public healthcare system. For example, in British Columbia, neither the new anti-arthritic drugs Celebrex and Vioxx, nor the Alzheimer's treatment Aricept, have been approved for reimbursement, severely limiting their availability. Further, the provincial approval times vary greatly from province to province, creating further inequities.

Price controls imposed by a government agency, the Patented Medicines Price Review Board (PMPRB), are the reason some prescription drugs cost less in Canada than in the United States. However, while keeping some prescription drug prices down through price controls, Canada has been unable to control overall drug spending. OECD statistics reveal that when the PMPRB was created in 1988, per capita expenditure on prescription drugs was $106; by 1996 that had doubled to $211 per person. One study of international drug price comparisons by Prof. Patricia Danzon of the Wharton School of the University of Pennsylvania concluded that, on the average, drug prices in Canada were higher than those in the United States. Some individual drugs, particularly generics, cost far more in Canada. For example, the anti-hypertensive drug atenolol is four times more expensive in Canada than in the United States. And a University of Toronto study found that the main effect of price controls on prescription drugs was to limit patients' access to newer medicines so that they had to rely more on hospitals and surgery.

All provinces require that chemically identical and cheaper generic drugs be substituted for more expensive brand-name drugs when they are available. However, British Columbia has gone farther with a ''reference price system.'' Under this system, the government can require that a patient receiving a drug subsidy be treated with whichever costs the least: (a) a generic substitute, (b) a drug with similar but not identical active ingredients or (c) a completely different compound deemed to have the same therapeutic effect. Patients are often forced to switch medicines, sometimes in mid-treatment, when the reference price system mandates a change. Twenty-seven percent of physicians in British Columbia report that they have had to admit patients to the emergency room or hospital as a result of the mandated switching of medicines. Sixty-eight percent report confusion or uncertainty by cardiovascular or hypertension patients, and 60 percent have seen patients' conditions worsen or their symptoms accelerate due to mandated switching.

Through limiting the availability of prescription drugs and controlling the prices of those that are available, Canada has succeeded only in preventing Canadians from obtaining drugs that might have reduced hospital stays and expensive medical procedures. The end result of this is that Canadians are getting a lower standard of health care at a higher cost than patients and taxpayers have a right to expect.

One lesson that Americans should learn from the Canadian experience is that when government pays for drugs, government controls the supply. As soon as government has to pay the bill, efforts are made to restrict the availability of newer and more effective drugs. The inevitable result is that other health expenditures like surgery and emergency visits increase, and patients suffer.

AMERICAN COMPETITIVENESS IN THE TWENTY-FIRST CENTURY ACT OF 2000

SPEECH OF

HON. EARL BLUMENAUER

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 3, 2000

Mr. BLUMENAUER. Mr. Speaker, expanding the number of H–1B visas for foreign workers is critical to the well being of Oregon's high-tech community. Given the strong economy, record low unemployment, and declining graduation rates in high-tech education fields, that industry is facing a critical shortage of highly educated workers. In Oregon, for example, we have openings for 800 software engineers and are currently unable to fill them.

Our education system is not producing the needed skilled workers for the high-tech industry. The H–1B visa program helps fill the void, but that's not all it does. The legislation we adopted last night helps develop our own workforce.

The bill keeps the current $500 application fee that employers pay for new H–1B visa holders, which produces $75 million in revenue each year. Less than two percent of the fees is for administrative expenses and the rest is used to enhance our educational system. This funding provides math, science, engineering, and technology post-secondary scholarships for low-income and disadvantaged students. It is also used to improve K–12 math and science education and for job training.

While this funding helps, I have joined many of my colleagues in pressing for more. I am a